ASSET PROTECTION PLANNING QUESTIONNAIRE
(SINGLE)

Date_________________________________ File No. _______________________

Home Phone No._______________________ Business Phone No. _______________________

E-mail Address________________________ Fax No. ___________________________

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Bring this information with you to our initial appointment.

A. PERSONAL DATA

Full Name ____
(print full legal name)

Street Address ____

City____ State___________ Zip ____________

Birth Date_____________________________________ Social Security No.

U.S. Citizen? Yes ___ No ___ Veteran? Yes ___ No ____

If widowed, please list name of spouse and date of death ____

Was your former spouse a Veteran? Yes ____ No ____

B. MEDICAL DATA

1. HEALTH

Diagnosis ____

Prognosis ____

If you are already in a nursing home, please indicate the name of the nursing home and the date first entered

____

2. PHYSICIAN

Full Name of Primary Physician ____

Street Address ____

City____ State__________ Zip ________________________

3. STATE PHARMACEUTICAL PLAN

Are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or any other state pharmaceutical plan?
Yes ____ No _____

C. MONTHLY INCOME

Social Security Benefits (include $96.40 Medicare Part B Deduction, if applicable) $___________________

Retirement Benefits (Gross) $___________________

Veterans Disability Income $___________________

Annuity Income $___________________

Rental Income $___________________

TOTAL MONTHLY INCOME $___________________

If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason.

Could this pension amount increase in the future? Yes ___ No ____

Do not include interest and dividend income on this form.

D. *LAST WILL AND TESTAMENT*

DISPOSITIVE INTENTIONS - CHILDREN

Child's Name	Address (including zip code)	Date of Birth

I

If you have children, do you wish to treat all of your children equally? ___ Yes ___ No

If not, why? ____

After your death, at what age do you want distributions to be made to your children?______________________
(e.g. typical plans provide for immediate distributions or for 1/3 at age 25, 1/2 of the remaining amount at age 30 and the entire remaining amount at age 35)

Are all of your children in good health? ___ Yes ___ No

Are any of your children disabled? ___ Yes___ No

Are any of your children receiving SSI or other form of government benefits? ___ Yes___ No

Do any of your family members have any problems with:

Creditors? ___ Yes___ No
Drug Addiction? ___ Yes___ No
Alcoholism? ___ Yes___ No
Spendthrift? ___ Yes___ No

GRANDCHILDREN

If you have grandchildren, do you wish to leave a specific amount of money or a percentage of your estate to your grandchildren? ___ Yes ___ No

If yes, please list:

Grandchild's Name	**Address (including zip code)**	**Date of Birth**

Do you wish to treat all of your grandchildren equally? ___ Yes ___ No

If not, why? ____

How much do you want to leave your grandchildren? ______________________________

At what age do you want distributions to your grandchildren? _________________________
(e.g., typical plans provide for immediate distributions or for 1/3 at age 25, 1/2 of the remaining amount at age 30 and the entire remaining amount at age 35)

OTHER BENEFICIARIES

Do you want your Will to benefit anyone other than children, grandchildren ie. Charity or other person?
___ Yes___ No

If yes, please list:

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount

EXECUTOR

Whom do you wish to serve as your Executor?

First Choice ____

Second Choice ____

TRUSTEE

Whom do you want to serve as your Trustee?

First Choice ____

Second Choice ____

E. POWER OF ATTORNEY

Do you currently have a Power of Attorney? _____ Yes _____ No

Whom do you want to designate as your Power of Attorney?

First Choice ____
(Name) (Address)

Second Choice____
(Name) (Address)

F. *LIVING WILL*

Do you want a Living Will? ___ Yes___ No

Do you want your Living Will to provide for withdrawal of artificial food and fluid? ___ Yes___ No

Do you want to donate your eyes or organs? ___ Yes ___ No

Whom do you want to make your medical decisions?

First Choice ____
(Name) (Address)

Second Choice____
(Name) (Address)

Do you want the person making your medical decisions to consult with any other person prior to acting?
___ Yes ___ No

If yes, with whom? ____

What are the name and address of your primary care physician?

Full Name of Physician ____

Street Address ____

City____ State___________ Zip______________

G. ***ASSETS/LIABILITIES***

Please insert the value of each asset/liability in the appropriate space.

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
PERSONAL EFFECTS		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MONEY MARKET ACCOUNT		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) BLOCK#___________ LOT#___________ (Obtain from Tax Bill)		
OTHER REAL ESTATE		
AUTOMOBILE(S)		
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
IRA		
NURSING HOME DEPOSIT		
OTHER		
OTHER		
TOTAL		

What did you pay for your current home including any improvements? $______________________-

Address of any real property other than personal residence:

(1)Street ____City ______________State________Zip

Tax Block #______________, Lot #______________ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? $ __________________

(2)Street ____City ______________State________Zip

Tax Block #______________, Lot #______________ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? $ ______________________

Name of Homeowner's Insurance Company ____

Street Address ____

City____ State__________ Zip ______________

Phone No.___________________________________ Policy No. ______________________________

H. GIFTS

Have you made gifts in excess of $5,000 in any one month, to an individual or group of individuals, or to a trust within the past 60 months? Yes _____ No. ___________

If yes, list below:

Recipient___________________________________ Date ______________ Amount ____________

Recipient___________________________________ Date ______________ Amount ____________

Recipient___________________________________ Date ______________ Amount ____________

Recipient___________________________________ Date ______________ Amount ____________

Recipient___________________________________ Date ______________ Amount ____________

Have you ever filed a Federal Gift Tax Return? Yes ____ No ____

If so, please state details

I. ***LIFE INSURANCE***

Name of Insurance Company_______________________________ Policy # ________________________

Street Address ____

City_______________________________ State_________________ Zip ____________________

Type of Policy____________________ Owner ____________________________________

Insured__________________________ Beneficiary ________________________________

Death Benefit: $__________ Face Value: $__________ Cash Value: $ _____________________

Name of Insurance Company_______________________________ Policy # ________________________

Street Address ____

City_______________________________ State_________________ Zip _____________________

Type of Policy____________________ Owner ____

Insured__________________________ Beneficiary ______________________________________

Death Benefit: $__________ Face Value: $__________ Cash Value: $ _________________________

Name of Insurance Company_______________________________ Policy # ___________________________

Street Address ____
City____ State_______________

Type of Policy____________________ Owner ______________________

Insured__________________________ Beneficiary _________________________

Death Benefit: $__________ Face Value: $__________ Cash Value: $ ___________________

Name of Insurance Company_______________________________ Policy # ________________________

Street Address ____

City_______________________________ State_________________ Zip _____________________

Type of Policy____________________ Owner ____

Insured__________________________ Beneficiary ______________________________________

Death Benefit: $__________ Face Value: $__________ Cash Value: $ _________________________

J. MISCELLANEOUS

Do you have any other legal issues which I should be aware of: Yes ____ No ____

If yes, please explain
____

K. REFERRAL

By Whom Were You Referred To This Office?

Name ____

Street Address ____

City____ State__________ Zip__________

Have you visited our Website? Yes ____ No ____

Do you have any ideas for improving our Website? If so, please discuss.

____

____

L. <u>CERTIFICATION</u>

The undersigned hereby represents to the Law Offices of Douglas A. Fendrick, LLC., that the information contained in this intake form is accurate and complete. The undersigned is aware that the law firm will rely on this information and further understands that the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

____